STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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LAURELBROOK SANITARIUM	114 CAMPUS DRIVE DAYTON, TN 37321

Amended POC

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS During complaint investigation number 26676, 25926, 26161and 26890 conducted on December 14 -21, 2010, at Laurelbrook Sanitarium, no deficiencies were cited in relation to the complaints under 42 CFR Part 482.13, Requirements for Long Term Care.	F 000	Disclaimer Statement Laurelbrook Nursing Home does not believe and does not admit that any deficiencies exist, before, during and after the survey. Laurelbrook Nursing Home reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceeding or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and Laurelbrook Nursing Home reserves all right to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceedings. Nothing contained in this Plan of Correction should be considered as a waiver of any potential applicable Peer Review, Quality Assurance or self critical examination privileges which Laurelbrook Nursing Home does not waiver, and reserves the right to assert in any administrative, civil, or criminal claim, action or proceedings. Laurelbrook Nursing Home offers its responses, credible allegations of compliance and plan of corrections as part of its ongoing efforts to provide quality of care to residents.	12-31-10
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Laura Hecht — TITLE: Asst. Administrator — (X6) DATE: 1-7-11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, observation and interview, the facility failed to ensure the physician was notified of the development of pressure sores for one resident (#15) of eleven residents reviewed for pressure sores. The findings included: Resident #15 was admitted to the facility on June 30, 2009 with diagnoses to include Closed Head Injury with Base Skull Fracture, Intracranial Hemorrhage and Diabetes. Medical record review of the Minimum Data Set dated October 14, 2010 revealed the resident had no problems with short or long term memory deficits; decision making skills was not impaired; required supervision to limited assistance with transfers, ambulation, and hygiene; used a wheel chair for mobility; experienced impairment on both sides of upper and lower extremities and was continent of bowel and bladder. Medical record review of the Care Plan, dated October 15, 2010 revealed the resident had not been identified as being at risk for skin breakdown. Interview with Licensed Practical Nurse (LPN) #2 revealed the resident required "...supervision or assistance with activities of daily living...skin break down of a blister on the right foot from the foot brace..."	F 157	F- 157 1) Resident #15's physician was notified regarding wounds on 12/31/10 by DON. 2) 100% audit was completed by the DON on 12/31/10 on all residents with pressure sores for physician notification. Aberrances were corrected immediately. 3) The policy and procedure for physician notification was reviewed by the DON on 12/31/10. Education was provided to the nursing staff on 12/31/10 by DON regarding this policy and procedure. Weekly skin assessments will be completed by Shift Nurse's and skin rounds will be completed by the Director of Nursing monthly to ensure physician notification. Aberrances will be corrected immediately. Residents utilizing devices will have devices placed on the medication administration record by ADON for visual skin inspection daily by the Charge Nurse. 4) An audit log will be completed on residents with devices and with skin issues weekly for four weeks, by the DON. Aberrances will be corrected immediately. These audits will continue monthly for three months. These audits will be reviewed quarterly by the QA committee for further recommendations.	12-31-10

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F 157	Continued From page 2 Interview in the resident's room on December 20, 2010 at 10:35 a.m., with the resident revealed the resident required the use of specialized shoes and braces for both lower legs; was unable to apply brace to right leg by self; had the outside of the right shoe "built up" about three to four weeks ago and the brace needed adjusting now as the brace was causing "sores" on the right foot; the social worker had scheduled the resident an appointment to have the brace adjusted on December 16, 2010 but the appointment was cancelled. Interview and observation in the resident's room on December 21, 2010 at 9:40 a.m., with LPN #2 revealed "...we're (nursing staff) putting salve on the blister and padding the area..." Observation revealed after removal of the resident's sock and brace, no dressing or padding was present on the resident's foot and the resident had a 1 cm (centimer) reddened area with a pin point open area in the center without drainage located on the upper outer aspect of the right foot and a 2 cm reddened area on the outer ankle which was non-blanchable (did not return to skin tone with pressure applied). Interview at this time confirmed LPN #2 was not aware of the area of skin breakdown on the ankle; was not aware the blister area was now an open area and no salve, dressing or padding had been applied. Medical record review of the Progress Note Listing for November 2010 revealed no documentation of the wound on the resident's right foot. Continued review revealed "December 14, 2010 at 10:19 a.m., (Social Services noted) Resident requesting to go back to (named clinic) for brace it is rubbing foot causing irritation.	F 157		12-31-10

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F 157	Continued From page 3 Appointment scheduled for December 16, 2010. Resident notified." Continued review revealed "December 20, 2010 at 3:09 p.m., (Social Services noted) December 16, 2010 appointment with (named clinic) cancelled due to snow and ice. Appointment rescheduled for December 30 at 11:30 a.m. Resident notified." Medical record review of the Physician's Progress notes revealed no documentation of skin breakdown for November or December 2010. Review of the facility policy Pressure Sores revealed "... 5. The physician will be in charge of the plan of care and provide appropriate orders for resolution of the pressure sore..." Interview in the sun room on December 21, 2010 at 12:25 p.m., with the Director of Nursing (DON), Director of Nursing in Training (DONIT), and Minimum Data Set and Care Plan Coordinator confirmed there was no documentation available to indicate the physician was notified of the change in the resident's skin to obtain orders for treatment of the pressure sore. Continued interview confirmed the facility failed to ensure the physician was notified of resident's changes in skin condition.	F 157		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and	F 314		

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F 314	Continued From page 4 prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, facility document review, facility policy review and interview, the facility failed to routinely assess and provide care and treatment of two pressure ulcers to prevent deterioation of the pressure ulcers for one resident (#1) and failed to prevent assess/pressure ulcer development for one resident (#15) resulting in harm to residents (#1, #15); failed to ensure residents identified at risk skin breakdown had routine skin assessments on an ongoing basis for two residents (#5, #11) of eleven residents reviewed for pressure ulcers. The findings included: Resident #1 was admitted to the facility on January 31, 2005 with diagnoses including Alzheimer's Dementia, Psychosis and Bowel and Bladder Incontinence. Medical record review of the Minimum Data Set (MDS) with a reference date of June 8, 2010 revealed the resident had a Stage 2 pressure ulcer. Review of the MDS with a reference date of December 09, 2010 revealed the resident had two Stage 2 pressure ulcers. Review of the Care Plan revealed the resident was on the facility's standard mattress, used a geri chair with a pressure relieving pad and included the following approaches: reposition every two hours, keep dry, measure and record size of wound every week.	F 314	F- 314 1) Resident #1's wound's were measured by DON on 12/22/10 and documented on the Wound Assessment Worksheet and the physician was contacted by ADON on 12/27/10 and orders were obtained. Resident #15's wound's were measured by Charge Nurse on 12/30/10 and documented on the Wound Assessment Worksheet physician was contacted by on 12/30/10 and orders were obtained. Resident #5's wound was measured by Charge Nurse on 12/23/10 and documented on the Wound Assessment Worksheet physician was contacted by Charge Nurse on 12/23/10 and orders were obtained. #11 wound was measured by ADON on 12/23/10 and documented on the Wound Assessment Worksheet physician was contacted by ADON on 12/23/10 and orders were obtained. 2) 100% skin audit was completed on all residents by Charge Nurse by 12/31/10. Residents with skin issues were documented on the Wound Assessment Worksheets and the residents physicians were contacted as indicated for treatment by the Charge Nurse by 12/31/10.	12/31/10

(2)

Medical record review revealed three September Wound Assessment Worksheets. The assessments for the 9th and 17th of September did not include ulcer measurements and were completed by an Registered Nurse (RN) who identified two areas within the ulcer as "stage 2," and one area as "stage 3 with thick white edge." Record review revealed the same RN documented the wound as a "Stg II" (Stage 2) seven days later on September 24, 2010. Medical record review revealed no further Wound

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F 314	Continued From page 5 Medical record review of the Wound Assessment Worksheet dated June 8, 2010 revealed no measurement or staging, but a picture with the notation "inside rt and lt (right and left) buttock crack...open" Medical record review revealed ten days later on June 18, 2010 the Wound Assessment Worksheet documented, "... location coccyx...length 1cm (centimeter)...width1.5 cm." Review revealed no depth or staging was recorded. Record review revealed three days later on June 21, 2010, Licensed Practical Nurse #1 (LPN) documented the coccyx ulcer as Stage 2 and documented the length and width as 1cm x (by)1cm. Medical record review revealed two July Wound Assessment Worksheets with the last assessment completed July 16, 2010 documented the coccyx ulcer as Stage 2, length 1.0 cm and width 0.15 cm. Medical record review of the August 2010 Wound Assessment Worksheet revealed skin assessments were completed on August 6, 17, 18, and 25. Record review revealed the last two August assessments documented the coccyx ulcer as a stage 2 measuring .5cm x 0.75cm x 0.5 depth. Medical record review revealed three September Wound Assessment Worksheets. The assessments for the 9th and 17th of September did not include ulcer measurements and were completed by an Registered Nurse (RN) who identified two areas within the ulcer as "stage 2," and one area as "stage 3 with thick white edge." Record review revealed the same RN documented the wound as a "Stg II" (Stage 2) seven days later on September 24, 2010. Medical record review revealed no further Wound	F 314	3) The process of identification and communication regarding skin assessments was reviewed and revised by the DON on 12/31/10 to include weekly skin assessments to be completed by each shift's Charge Nurse per the new daily schedule located at the nurse's station. Assessments will be reviewed during the Thursday clinical meeting by the clinical IDT which includes the DON using the wound assessment report. The DON will in service this process change to licensed staff by 12/31/10.	12-31-10

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F 314	Continued From page 6 Assessment Worksheets were available in the record. Medical record review of the physician's progress note dated October 6, 2010 revealed a notation by the physician related to the left hip having a "...5mm (millimeter) open decubitus-minor." Further review of the progress note revealed there was no reference to the pressure ulcer of the coccyx. Review of the subsequent physician's progress note documented by the Nurse Practitioner (NP) on November 3, 2010 revealed "Decub. L.hip (Decubitus left hip) is almost resolved...one on bottom still open, but with "new" tissue forming..." Review of the NP's note on December 1, 2010 revealed "1 Decub. L. hip remains the same...staff request to try O2 (Oxygen) therapy...unsure if it will help or not." Review revealed no documention regarding the pressure ulcer of the coccyx. Review of a physician's order dated December 1, 2010 revealed "OK to use O2 therapy L hip Decub 4X (times) daily." Review of a physician's order dated December 10, 2010 revealed "Wet to dry drsg (dressing) to coccyx wound BID (twice daily) X 7 days and reeval (reevaluate)." Interview in the sunroom with the DON as the record was reviewed on December 15, 2010 at 1:15 p.m., revealed one additional record of the coccyx measurement was completed October 20, 2010, on Weekly Wound Care Notes and measurement of the coccyx ulcer was recorded, "2.5 cm by 1.2 cm...1 cm depth." Further interview confirmed there were no additional measurements of the coccyx ulcer since October	F 314	4) The DON will review the wound tracking and communication report sheets weekly to ensure documentation, treatment, orders and that the incidence of any new issue has been identified and addressed.. This review will be done weekly for four weeks to ensure nursing department is capturing new wounds and completing documentation in a timely manner. Aberrances will be corrected immediately. The DON will audit 10% of residents to sure skin issues are identified weekly for four weeks. These audit logs will continue monthly for three months. These audit logs will be reviewed quarterly by the Quality Assurance Committee to include (Medical Director, DON, and Administrator) for further recommendations.	12-31-10

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F 314	Continued From page 7 10, 2010. Medical record review of the Wound Assessment Worksheets for the left hip ulcer revealed an initial assessment on July 16, 2010, with a stage 2 measuring 0.5 cm x 1.0 cm and 0.5 cm depth. Review of the Wound Assessment Worksheet for August 23, 2010 revealed the left hip ulcer was a stage 3 measuring 1.5 cm x 1.0cm x 0.5 cm depth. Review of the Wound Assessment Worksheet for September 24, 2010, revealed the left hip ulcer was a stage 2 measuring 1cm (length) x 1cm (width) and 0.3 (depth). Review of the medical record revealed no further measurements or assessments documented for the left hip ulcer. Observation with Certified Nursing Assistant #1 (CNA) on December 15, 2010 at 11:00 a.m., revealed resident #1 lying in the bed. Observation revealed a large amount of loose bowel movement in the resident's incontinence brief (around the coccyx ulcer). Observation of the coccyx ulcer with CNA #1, after the resident was cleaned, revealed an ulcer immediately above the anal area with more depth at the proximal end and the skin borders surrounding the ulcer had a thick white appearance. During the observation, CNA #1 verified the ulcer did not have a dressing applied. Observation of resident #1's coccyx and left hip pressure ulcers on December 15, 2010, at 11:15 a.m., with Licensed Practical Nurse #1 (LPN) revealed LPN #1 stated, "...don't measure wounds...don't know how to measure depth..."	F 314		

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F 314	Continued From page 8 Interview with LPN #1 at the time of the observation revealed a measurement of the coccyx ulcer of 3 cm x 1.5 cm and unable to gauge depth, and LPN #1 agreed depth at the proximal end was greater than at distal end. Interview revealed the LPN stated both ulcers were, "Stage 3" and the left hip ulcer measured 1.5 cm length and 0.75 cm width. Interview with the Minimum Data Set Coordinator (MDS) by telephone on December 16, 2010 at 12:50 p.m., revealed the Coordinator stated a MDS assessment had been completed for resident #1 on December 9, 2010 and the two pressure ulcers were assessed as Stage 2. During the interview, the Coordinator stated there was not a visual assessment of the wound completed prior to the MDS assessment. During an interview with the NP by telephone on December 16, 2010 at 1:50 p.m., the NP stated was unaware the coccyx ulcer had deteriorated, and stated the ulcer had not been observed in "a few weeks." Interview confirmed the NP had not observed the wound on December 15, 2010, prior to ordering a wet to dry dressing every eight hours. Review of the Pressure Sores policy revealed " ...2. c. Prevent further contamination ...4. Care Plan objectives will be evaluated to monitor the healing process and to initiate alternative interventions in the event of a pressure sore not healing, getting larger..." Review of the facility's Skin and Wound Care	F 314		

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F 314	Continued From page 9 policy revealed "...Wounds will be treated according to a physician order." Interview in the sunroom with the DON on December 15, 2010 at 1:15 p.m. verified pressure ulcers were to be measured weekly and documented on the Weekly Wound Care Notes and this had not been completed since October 20, 2010. Interview verified the pressure ulcer on the coccyx had not been staged since September 24, 2010 and the pressure ulcer of the left hip had not been measured or staged as required by the facility's policy since September. Interview verified resident #1 was completely incontinent of bowel and the two pressure ulcers did not presently have a treatment regime ordered to include a dressing for the ulcers. Interview verified the NP had written an order for a wet to dry dressing of the coccyx ulcer during an onsite visit on December 10, 2010. Further interview comfirmed the pressure ulcers had not been assessed by the DON, RN, or an LPN who was trained to measure/stage ulcers. Interview confirmed the pressure ulcer on the coccyx had continued to deteriorate from the date of discovery to the present time and there had not been any change in the treatments except for the use of wet to dry dressings and oxygen therapy to the left hip decubitus. Interview confirmed the facility's policy to prevent the pressure ulcers from being contaminated was not followed and confirmed the facility failed to provide the necessary care/treatment to prevent deterioration of the pressure ulcers. Resident # 15 was admitted on June 30, 2009 with diagnoses to include Closed Head Injury with	F 314		

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OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 314	Continued From page 10 Base Skull Fracture, Intracranial Hemorrhage and Diabetes. Medical record review of the Minimum Data Set dated October 14, 2010 revealed the resident had no problems with short or long term memory deficits; decision making skills was not impaired; required supervision to limited assistance with transfers, ambulation, and hygiene; used a wheel chair for mobility, experienced impairment on both sides of upper and lower extremities and was continent of bowel and bladder. Medical record review of the Care Plan, dated October 16, 2010 revealed the resident had not been identified as being at risk for skin breakdown. Interview with Licensed Practical Nurse (LPN) #2 revealed the resident required "...supervision or assistance with activities of daily living...skin break down of a blister on the right foot from the foot brace..." Interview in the resident's room on December 20, 2010 at 10:35 a.m., with the resident revealed the resident required the use of specialized shoes and braces for both lower legs; was unable to apply brace to right leg by self; had the outside of the right shoe "built up" about three to four weeks ago and the brace needed adjusting now as the brace was causing "sores" on the right foot; and the social worker had gotten the resident an appointment to have the brace adjusted on December 16, 2010 but the appoint was cancelled. Interview and observation in the resident's room on December 21, 2010 at 9:40 a.m., with LPN #2	F 314		

F 314	Continued From page 11 revealed "...we're (nursing staff) are putting salve on the blister and padding the area..." Observation revealed after removal of the resident's sock and brace, no dressing or padding was present on the resident's foot and the resident had a 1 cm reddened area with dried skin surrounding the reddened area and a pin point open area in the center without drainage located on the upper outer aspect of the right foot and a 2 cm reddened area on the outer ankle which was non-blanchable (did not return to skin tone with pressure). Interview confirmed LPN #2 was not aware of the area of skin breakdown on the ankle; was not aware the blister area was now an open area; and confirmed no salve, dressing or padding had been applied. Medical record review of the Progress Note Listing for November 2010 revealed no documentation of the wound on the resident's right foot. Continued review revealed "December 14, 2010 at 10:19 a.m., (Social Services note) Resident requesting to go back to (named clinic) for brace it is rubbing foot causing irritation. Appointment scheduled for December 16, 2010. Resident notified." Continued review revealed "December 20, 2010 at 3:09 p.m., (Social Services note) December 16, 2010 appointment with (named clinic) cancelled due to snow and ice. Appointment rescheduled for December 30 at 11:30 a.m. Resident notified." Medical record review of the Physician's Progress notes revealed no documentation of skin breakdown for November or December 2010. Medical record review revealed no documentation	F 314	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 12 of periodic or ongoing skin assessments present in the medical record. Review of the facility Wound Tracking Forms revealed documentation available: October 10, 2010 - no documentation on form related to the resident's skin condition; November 29, 2010 - no documentation on the form related to the resident's skin condition, and December 19, 2010 - no documentation on form related to the resident's skin condition. Continued review revealed no other documentation of skin assessments. Review of the facility policy Pressure Sores revealed "...If a resident...develops a pressure sore, he/she will receive appropriate care and treatment to heal and prevent further development of other pressure sores...1. All residents will be assessed for skin integrity upon admission through: Nursing assessments, MDS (Minimum Data Set), CNA daily observation during care. 2. Assessments and triggers will identify at risk residents...4. Care Plan objectives will be evaluated to monitor the healing process and to initiate alternative interventions in the event of a pressure sore not healing, getting larger or skins of additional skin breakdown. 5. The physician will be in charge of the plan of care and provide appropriate orders for resolution of the pressure sore..." Review of the facility policy Skin and Wound Care revealed "...all residents will be free from tears, wounds, and pressure sores...Resident's skin will be assessed upon admission...upon return from hospitalizations, the resident's skin will be thoroughly reassessed...Certified Nursing Assistants will assess each resident in their care	F 314		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	44E200	A. BUILDING _____ B. WING _____	12/21/2010

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F 314	Continued From page 13 on an ongoing basis and report any changes to the resident to the charge nurse...Residents' skin will be assessed thoroughly during each bath...wounds will be treated according to a physician order. Interview in the sunroom on December 21, 2010 at 12:25 p.m., with the Director of Nursing (DON), Director of Nursing in Training (DONIT), and Minimum Data Set and Care Plan Coordinator confirmed the facility did not have documentation of periodic, ongoing, accurate and comprehensive skin assessments on a resident identified as being at risk for skin breakdown. Continued interview confirmed the facility failed to identify the pressure areas and provide treatment/services to prevent skin breakdown. Continued interview confirmed no documentation available to indicate the physician was notified of the change in the resident's skin condition. Resident # 5 was admitted on June 23, 2008 with diagnoses to include Dementia, Depression, Mental Retardation, Schizophrenia, Agitation and Constipation. Medical record review of the Minimum Data Set, dated August 10, 2010 revealed the resident had short and long term memory deficits; impaired decision making skills; was totally dependent on staff and required two person assist with positioning in bed, transfers, ambulation and hygiene and was incontinent of bowel and bladder. Medical record review of the Care Plan, dated January 29, 2010 and updated on August 10, 2010 revealed the resident had been identified as	F 314		

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F 314	Continued From page 14 being "...at risk for skin breakdown...Monitor skin q (every) shift for s/sx (signs and symptoms) of potential skin breakdown (example: redness/discoloration or open areas). Alert charge nurse if observed for notification of physician as needed for treatment orders..." Interview in the resident's room on December 20, 2010 at 10:35 a.m., with Licensed Practical Nurse (LPN) #2 revealed the resident required "...total assistance...no skin break down..." Interview and observation in the resident's room on December 21, 2010 at 9:40 a.m., with LPN #3 and Certified Nursing Assistant (CNA) #2 revealed "...no skin breakdown..." Observation at this time revealed the resident had a ½ cm (centimeter) reddened area with a dry abraded or rash like appearance located on the left inner aspect of upper ¼ fold of the buttocks. Interview with LPN #3 and CNA #2 confirmed neither had been aware of the change in skin condition. Medical record review of the Progress Note Listing dated December 11, 2010 at 6:23 p.m., revealed "CNA's state resident has reddened areas to both buttocks. About 1 X (by) 2 cm in size on both cheeks. No open area noted. Turn every two hours and put back to bed immediately after meals and on side. Continued review revealed no further notation related to the resident's skin. Medical record review of the Physician's Progress notes revealed December 1, 2010 was the last documentation available and revealed no documentation of skin breakdown for November or December 2010.	F 314		

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F 314	Continued From page 15 Medical record review revealed no documentation of periodic or ongoing skin assessments present in the medical record. Review of the facility Wound Tracking Forms revealed documentation available: April 16, 2010 - Skin tear Rt (right) forearm; October 10, 2010 - Skin tear Rt arm; November 29, 2010 - Skin tear Rt forearm; and December 19, 2010 - no documentation on form related to the resident's skin. Continued review revealed no other documentation of skin assessment or outcome of the patient's wounds on the Wound Tracking Forms. Review of the facility policy Pressure Sores "...If a resident...develops a pressure sore, he/she will receive appropriate care and treatment to heal and prevent further development of other pressure sores...1. All residents will be assessed for skin integrity upon admission through: Nursing assessments, MDS (Minimum Data Set), CNA daily observation during care. 2. Assessments and triggers will identify at risk residents...4. Care Plan objectives will be evaluated to monitor the healing process and to initiate alternative interventions in the event of a pressure sore not healing, getting larger or skins of additional skin breakdown. 5. The physician will be in charge of the plan of care and provide appropriate orders for resolution of the pressure sore..." Review of the facility policy Skin and Wound Care revealed "...all residents will be free from tears, wounds, and pressure sores...Resident's skin will be assessed upon admission...upon return from hospitalizations, the resident's skin will be thoroughly reassessed...Certified Nursing Assistants will assess each resident in their care	F 314		

	visible/exposed skin for redness whenever care is being provided. Report any redness or break in skin to charge nurse...toilet resident every two hours..."			

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F 314	Continued From page 16 on an ongoing basis and report any changes to the resident to the charge nurse...Residents' skin will be assessed thoroughly during each bath...wounds will be treated according to a physician order. Interview in the sunroom on December 21, 2010 at 12:25 p.m., with the Director of Nursing (DON), Director of Nursing in Training (DONIT), and Minimum Data Set and Care Plan Coordinator confirmed the facility did not have documentation of periodic, ongoing, accurate and comprehensive skin assessments on a resident identified as being at risk for skin breakdown. Resident # 11 was admitted on April 20, 2009 with diagnoses to include Dementia with Behaviors, Depression, Hypertension, Cardiovascular Disease and Osteoporosis. Medical record review of the Minimum Data Set dated November 22, 2010 revealed the resident had short and long term memory deficits; impaired decision making skills; was totally dependent on staff and required two person assist with positioning in bed, transfers, and hygiene; was non-ambulatory and was incontinent of bowel and bladder. Medical record review of the Care Plan, dated November 23, 2010 revealed "...Reposition resident every two hours and use pillows to protect bony prominences...assess skin thoroughly on bath days and observe visible/exposed skin for redness whenever care is being provided. Report any redness or break in skin to charge nurse...toilet resident every two hours..."	F 314		

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F 314	Continued From page 17 Interview in the resident's room on December 20, 2010 at 10:05 a.m., with Licensed Practical Nurse (LPN) #2 revealed the resident required "...total assistance...no skin break down..." Interview and observation in the resident's room on December 20, 2010 at 1:30 p.m., with LPN #3 and Certified Nursing Assistant #8 and #9 revealed "...no skin breakdown..." Observation at this time revealed the resident had a 1 cm reddened area with a dry abraded or rash like appearance located on the right inner aspect of upper ¼ fold of the buttocks. Interview with LPN #3 and CNA #8 and #9 confirmed neither was aware of the change in skin condition. Medical record review of the last documented Progress Note Listing dated November 25, 2010 and December 8, 2010 revealed no documentation of skin assessments. Medical record review of the Physician's Progress notes documentation available for November and December 2010 revealed no documentation of skin condition. Review of the facility Wound Tracking Forms revealed documentation available: April 16, 2010, October 10, 2010, and December 19, 2010 with no documentation on the forms related to the resident's skin condition. Review of the facility policy Pressure Sores revealed "...If a resident...develops a pressure sore, he/she will receive appropriate care and treatment to heal and prevent further development of other pressure sores...1. All residents will be assessed for skin integrity upon admission through: Nursing assessments, MDS	F 314		

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F 314	Continued From page 18 (Minimum Data Set), CNA daily observation during care. 2. Assessments and triggers will identify at risk residents...4. Care Plan objectives will be evaluated to monitor the healing process and to initiate alternative interventions in the event of a pressure sore not healing, getting larger or skins of additional skin breakdown. 5. The physician will be in charge of the plan of care and provide appropriate orders for resolution of the pressure sore..." Review of the facility policy Skin and Wound Care revealed "...all residents will be free from tears, wounds, and pressure sores...Resident's skin will be assessed upon admission...upon return from hospitalizations, the resident's skin will be thoroughly reassessed...Certified Nursing Assistants will assess each resident in their care on an ongoing basis and report any changes to the resident to the charge nurse...Residents' skin will be assessed thoroughly during each bath...wounds will be treated according to a physician order. Interview in the sun room on December 21, 2010 at 12:25 p.m., with the Director of Nursing (DON), Director of Nursing in Training (DONIT), and Minimum Data Set and Care Plan Coordinator confirmed the facility did not have documentation of periodic, ongoing, accurate and comprehensive skin assessments on a resident identified as being at risk for skin breakdown. Continued interview confirmed the facility failed to assess the resident's skin to prevent skin breakdown.	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident	F 323		

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F 323	Continued From page 19 environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, the facility failed to provide assistive devices/hands on contact to prevent falls for two (#3, #8) of twenty three residents reviewed. The findings included: Resident #3 was admitted to the facility on April 26, 2009 with diagnoses including Hypertension, Cerebrovascular Accident, Right Hemiparesis and a history of contractures. Review of the Minimum Data Set dated May 4, 2010, (Prior to the resident's injuries) revealed the resident was non-ambulatory and required assistance of two staff for transfer; the resident had minimum difficulty with long and short term memory; difficulty with decision making skills and required total care for all activities of daily living. Review of the plan of care updated July 7, 2010 revealed the resident required the use of a sling for all transfers. Observation on December 14, 2010 at 12:45 p.m. revealed the resident seated in a geri chair in the resident's room, facing the back wall, with the lower extremities in the up position.	F 323	F323 1) DON re-in-serviced CNA's on following Plan of Care on resident #3 and using a sling to transfer resident. DON re-in-service CNA's on following Plan of Care for resident #8 that they are a two person assist at all times when not in bed or in specialized thigh restraints in chair. Completed 12/31, written in-serviced material placed into in-service book to be read and signed by staff not in attendance. 2) Floor Supervisor created mini Care Plan sheets that includes the care plans for each teams residents. This is to be located in the CNA care plan binder at the nurse's station. CNA's will carry these mini care plan sheets with them during shift and refer to them when they have questions regarding Plan of Care for their residents. 3) Floor Supervisor will monitor compliance by randomly choosing 2 residents and verifying CNA's are following the plan of care. This will be monitored weekly (Wednesday) x 4 weeks and then monthly x 2 months. 4) DON to report compliance to QA Committee.	12-31-10

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F 323	Continued From page 20 Observation on December 15, 2010 at 9:15 a.m. revealed two CNA's (Certified Nursing Assistants) in the resident's room preparing to transfer the resident from the geri chair to the bed. Continued observation revealed the CNA's placed their arms under the resident's arm pits, holding the resident under the contracted legs, and transferred the resident from the geri chair to the bed. Interview with the (new) Director of Nursing on December 20, 2010, at 11:45 a.m., at the nursing station confirmed the resident required a sling for all transfers. Resident #8 was admitted to the facility on January 20, 2009 with diagnoses including Depressive Disorder, Severe Mental Retardation, Unsocial Aggression, Convulsions, Cereberovascular Accident and Seizures. Review of the Minimum Data Set dated July 6, 2010, revealed the resident was an extensive assistance of two person transfer and ambulation, and had a history of falls. Review of the nursing notes dated September 24, 2010, at 9:16 p.m., revealed, " ...While CNA's were preparing to change pt. (patient)...leaned forward and fell from...chair hitting...head...Fall caused a laceration about 1 ½ inches on the top of...head along the sagital suture line...Laceration not deep and does not require emergency treatment...." Review of facility documentation and post incident investigation revealed "...an observed fall...on September 24, 2010 at 8:15 p.m., the resident leaped forward out of...(special) chair...resident	F 323		

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F 323	Continued From page 21	F 323		

hit the floor causing a 1 ½ inch laceration to top of head..." Continued review of the documentation revealed the plan of correction stated "...When caring for (the resident) there should be hands on at all times to prevent (the resident) from moving forward while unclamped from chair...In-service CNA's to get supplies/items needed prior to starting care." Continued review of the documentation revealed "...the physician and family was notified on September 24, 2010, at 8:30 p.m...."

Review of the resident's care plan dated January 21, 2009, revealed the resident required the use of a special chair with attached thigh straps for daily use as a restraint; padded side rails up times 2 when in bed at all times, and a clip alarm on at all times.

Observation on December 14, 2010, at 12:45 p.m., revealed two Certified Nursing Assistants (CNAs) in the resident's room preparing to provide incontinence care for the resident. Continued observation revealed the CNAs removed the alarm and thigh straps and lifted the resident under the arms to a standing position and provided incontinence care.

Interview with CNA #6 on December 21, 2010, at 11:02 a.m., by phone stated the clip alarm and the restraint had been removed at the time of the fall.

Interview with the Director of Nursing on December 21, 2010, at 11:30 a.m., in the

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F 323	Continued From page 22 director's office confirmed the resident was a two person transfer and the facility had implemented hands of contact at any time the resident's leg straps had been removed to prevent the resident from leaning forward.	F 323		